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British Black and Minority Ethnic groups' participation in the care sector

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About *Social Care Workforce Periodical*

The *Social Care Workforce Periodical* (SCWP) is a regular web-based publication, published by the Social Care Workforce Research Unit, King's College London. *SCWP* aims to provide timely and up-to-date information on the social care workforce in England. In each issue, one aspect of the workforce is investigated through the analysis of emerging quantitative workforce data to provide evidence-based information that relates specifically to this workforce in England. The *Social Care Workforce Periodical* provide in-depth analyses of the latest available workforce data including the National Minimum Data Set in Social Care (NMDS-SC); for further details on NMDS-SC please visit http://www.nmds-sc-online.org.uk/. We welcome suggestions for topics to be included in future issues.

About the author

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Executive Summary

"Ethnicity" is a socially constructed concept with little biological validity but is important to individual identity as well as to how the person is perceived by society. Ethnicity and nationality are two overlapping but different elements of a person's identity that is constructed through heritage, community and norms. There has been recent interest in understanding the profile of migrants working in the care sector in the UK and other economically developed countries. However, little is known about the participation of British (United Kingdom) workers from Black and Minority Ethnic (BME) groups in the UK care sector who are not recent migrants. The reasons why this might be an important area to explore rest on several grounds. For example, is social care employment one that is characterised by equal opportunities? In social work, for example there is some evidence that the profession has attracted many more BME applicants than other professions (Evaluation of the Social Work Degree in England Team 2008). Of course, BME groups in the UK are by no means homogenous because socio-economic, religious and cultural factors vary widely across different BME groups. Another reason for investigating BME groups' participation in social care work is to provide evidence for refining recruitment strategies should the need arise. . For example, a number of studies have highlighted parents' important influence in the career choices of young BME people (Helm et al 2002; Greenwood and Bithell 2003, Connor et al 2003). Specific to the care sector, Robinson and colleagues (2006) have identified negative perceptions of (some) health and social care careers among different BME groups in the UK. The reasons for such perceptions are multi-faceted but include perceived difficult working conditions, poor pay and fear of institutional racism (Sheffield et al 1999, Klem and Notter 2001).

The United Kingdom (UK) has been multi-cultural and multi-ethnic for very long periods in many areas. Different population moves characterise the UK. Recent statistics suggest that BME groups (including recent migrants) now account for 73 per cent of the UK's total population growth, due to differences in fertility rates and some inward migration (Parliament Office of Science and Technology 2007). However, currently, over 50 per cent of people identified as having Asian or Black ethnicity were born in the UK (Ahmad and Bradby 2007). One area of research that has attracted interest in social care recently has been the impact of migration on the care workforce following the enlargement of the EU (see Hussein et al 2010). In contrast, there has been less research on the contribution of BME workers to the sector more generally.

The high demand for social care and the increasing ethnic diversity of people who are receiving social care services (Lievesley 2010) call for continued efforts in recruitment overall and suggest the benefits of welcoming a diverse workforce. The current analysis focuses on contribution of British (UK) BME workers to the English care sector, separating ethnicity from nationality. Using the National Minimum Data Set for Social Care (NMDS-SC) we explore whether the care sector attracts British BME people with similar or different profile from

that of White British workers (using Census definitions). Are there variations in specific roles, working patterns and types of services provided by BME British workers compared to their White British counterparts?

Analysis of the NMDS-SC, June 2011, focusing on workers' records with valid information on both ethnicity and nationality, shows that 7.5 per cent (n=26,789) of the workforce are identified by their employers to be British BME workers. This percentage is much lower than the 19 per cent identified as belonging to BME groups without accounting for nationality. In other words, much of the data relating to BME workers may well be referring to recent migrants. Focusing on those identified as British (n=307,575), 91.3 per cent were identified as being of 'white' ethnicity and 8.7 (n=26,789) as being from BME groups. The analysis indicates the following:

- The average age of both BME and white British workers is in the early 40s, albeit British BME workers are slightly younger in age.
- Previous analysis has shown that younger workers (18-25 years) in the care sector are less ethnically diverse than older workers.
- Proportionally more British BME workers are men than white British workers (11.6% vs. 8%),
- Significantly more white British workers were reported by their employers to have any form of disability than BME British workers.
- More BME British workers have no relevant qualifications compared to their white British counterparts (12% vs. 4%).
- Similar to the overall workforce, the vast majority of BME British workers undertake direct care work, however, BME British workers are significantly over represented in professional job roles but less represented in managerial and other job roles.
- Similar to migrant workers, BME British workers are over represented in registered nurses posts; but they differ in terms of representation in other jobs. BME British workers are relatively more represented within counselling and in the social work profession (forming 11 per cent of social workers and counsellors).
- In terms of working patterns, the current analysis indicates that significantly more BME British workers than white British are employed on flexible and temporary arrangements and through agencies.
- The current analysis confirms the concentration of all British workers within the private sector, however, relatively more BME than white British workers are employed in the private sector.
- The over representation of BME British workers in the private sector (where working conditions may be more demanding and pay is often lower) combined with higher chances of temporary employment status raise questions about the overall job security of this group relative to other workers.
- On average white British workers have more years of experience in the sector than BME workers.
- Analysing data related to source of recruitment to current jobs, the care sector appears to be attracting more white British workers from outside the occupational sector than BME British workers.

- Results from a logistic regression model show that differences in relation to highest qualification levels and job roles are statistically significant. Such strong findings, combined with findings related to source of recruitment of British BME workers being more likely to be from within the care sector, may be indicative of the perceived unattractiveness of the care sector as a career 'choice' for British BME people.
- Local population density and level of rurality of an area are significantly associated with the level of participation of BME British groups in the care sector. The findings indicate that participation levels are highest in London (OR=6.33, $p<0.001$) where the local population is the most ethnically diverse in the UK. Similarly, British BME workers are significantly more likely to be working in predominantly urban than rural areas (OR=1.82, $p<0.001$).
- The logistic regression model results highlight several organisational characteristics that are significantly associated with the likelihood of BME British workers' presence in the workforce.
- British BME workers are more likely to be working within organisations[1] with low vacancy and turnover rates, possibly painting a picture of higher employment attachment among British BME than white workers.
- Findings related to qualifications and specific job role patterns may reflect both the attitude of BME groups to different jobs as well as the skills capital of different groups of BME workers. BME British workers holding specialised qualifications, especially social work and nursing, are able to perform professional jobs. However, there is another group of workers lacking any relevant qualifications who are likely to perform basic care jobs, after completing their induction (given the significantly higher likelihood of BME workers to complete their induction).
- From a policy perspective the findings highlight the need to promote careers in social care and to consider the nature and delivery of information provided to BME communities to younger age groups and their parents, such as at times when considering secondary school options.

[1] Referred to as 'establishments' in the NMDS-SC files

Background

"Ethnicity" is a socially constructed concept with little biological validity that is key to an individual identity as well as how the person is perceived by society. People may use ethnicity in addition to other visible markers, such as skin colour and dress code, as a way of grouping others in a 'normative order', despite knowledge that such characteristics are not associated with physiological or other differences (Hauskeller 2006, Li 2008). There is evidence that social markers, among others, are used to classify and evaluate other people's cultures (Johnstone and Kanitsaki 2008). The literature suggests that workers from different minority ethnic groups, particularly those with visible social markers, are likely to experience different levels of overt and covert racism and discrimination in the workplace (Holgate 2005, Doyle and Timonen 2009, Stevens et al 2011).

Ethnicity and nationality are two overlapping but different elements of a person's identity that are constructed through heritage, community and norms. There has been recent interest in understanding the profile of migrants working in the care sector in the UK and other more economically developed countries. However, little is known about British workers from Black and Minority Ethnic (BME) groups' participation in the UK care sector. While the choice of care work for migrants can, at least partially, be influenced by the desire to migrate in the first place, or to participate in the labour market after arrival (Hussein et al 2010), the choice of a career in the care sector for the British BME community is likely to be governed by a different set of factors. While BME groups in the UK by no means can be considered to be homogenous and socio-economic, religious and cultural factors vary across different groups of BME communities, a number of studies have highlighted the importance of parents' influence over career choices made by young BME people (Helm et al 2002, Greenwood et al 2006, Connor et al 2004). Specific to the care sector, Robinson and colleagues (2006) identified a negative perception of some health and social care careers among different BME groups in the UK. The reasons for such perception are multi-faceted and include perceived difficult working conditions, poor pay and fear of institutional racism (Klem and Notter 2001, Giga et al 2008).

The UK has been multi-cultural for many centuries, with large-scale migration from former colonies after the Second World War in varying patterns. Many such immigration movements were linked to labour needs, for example, large labour movement from Pakistan and India in the 60s and 70s. Nowadays, over 50 per cent of people identified as having Asian or Black ethnicity were born in the UK (Ahmad and Bradby 2007). Additionally, other 'invisible' minorities have almost always existed as part of the British society, for example, Irish Catholics. More recent changes in migration patterns, political changes, European expansion and globalisation in general have further enriched the mixture of ethnicities in the UK. The UK is now referred to as 'superdiverse' (Finney and Simpson 2009).

According to the last published census data (2001; ONS 2009), 92 per cent of the UK population is White, which includes significant White minorities such as Irish people. A further 4 per cent of the population is Asian or Asian British, 2 per cent are Black or Black British, and 1.5 per cent are of mixed ethnicity. Black and Minority Ethnic (BME) populations are concentrated in urban areas, particularly in deprived areas, where they make up a much bigger share of the population. However, the distribution of BME groups in the UK has been dramatically changing since the last published census, and they are becoming less geographically segregated. The UK is likely to become further multi-ethnic in the future. BME groups now account for 73 per cent of the UK's total population growth, due to differences in fertility rates and some inward migration (Parliament Office of Science and Technology 2007).

The UK may be a diverse society, and growing even more diverse every year, however, health and socio-economic ethnic-inequalities in life chances, including employment opportunities and career progression, are very wide (ONS 2009, Hills 2010). The high demand for social care and the increasing diversity of people who are receiving services, Lievesley (2010), call for continued efforts in recruitment and suggest the benefits of welcoming a diverse workforce. In addition to inequalities in service access and some assumptions that some ethnic groups do not require services as they *'look after their own'* (Butt and O'Neil 2004), there are considerable inequalities within the workforce. Within the social care workforce issues of discriminations and racism are widely reported, especially among migrant workers or workers who 'look' different (Hussein et al 2010, Cangiano et al 2009). Recent research shows that British BME staff may sometimes similarly be subjected to racism and discrimination and that social markers, such as skin colour, can trigger racist behaviour (Stevens et al 2011).

Of great importance is quality of services, where workforce racial and ethnic diversity is considered to be a key element in the provision of culturally competent care (Cohen et al 2002, Manthorpe and Bowes 2010). The term cultural competence denotes the knowledge, skills, attitudes, and behaviour required of a practitioner to provide optimal health or care services to people from a wide range of cultural and ethnic backgrounds. However, to achieve workforce diversity two issues need to be considered: first, the numerical construction and profile of the workforce and second, the structural relationships among groups within the workforce; thus recognising three elements: power, status and numbers. British BME workers may be well placed to have both an understanding of British culture as well as appreciation and awareness of cultural and racial backgrounds of some of the growing minority communities of social care users.

While migrant workers form a considerable part of the care workforce in England, we aim to explore the effect of ethnicity and separate this from the other dynamics associated with migration. The current analysis focuses on contribution of British BME workers to the English care sector, separating ethnicity from nationality. Using the National Minimum Data Set for Social Care (NMDS-SC), June 2011, we explore whether the care sector attracts British BME people with similar or different profile from that of British white workers. Are

there variations in specific roles, working patterns and types of services provided by BME British workers compared to White British workers? We also explore the interactions between three main factors of identity: ethnicity, gender, and age, and control for nationality by focusing only on workers identified as British. The NMDS-SC does not collect information on other factors influencing identity, including religious or sexual orientation; however, information related to reported disability (which can be physical, mental or other) are included in the analysis.

Local area population composition is likely to affect the characteristics of available workers thus directly influencing the contribution of different groups in the local labour market. Additionally, local population composition not only affects the diversity of labour supply but also influences the diversity of users of care services and consequently highlights possible demand for a more or less diverse workforce. The current analysis will reflect local area population composition variability by accounting for the effect of region and level of rurality of localities. The analysis starts by providing an understanding of the context of workforce composition with a focus on ethnicity and explores the interactions between ethnicity and other personal, employment and organisational characteristics. We explore the relationships between the prevalence of British BME workers and other workers with local area characteristics. We then model the relationship between various characteristics and workers' identity as British BME individuals. The model and analysis aim to identify any inequalities and structural relationships in the pattern of distribution of British BME workers within the care sector, in terms of job roles, types of organisations and main service user groups.

Methods

The aim of the current analysis is to provide an in-depth understanding of the contribution of British BME workers to the care sector and to separate such contribution from that of migrant workers (defined here as workers not born in the UK or not having UK citizenship). We investigate the contribution and characteristics of British BME workers in the care sector in comparison to White British workers. The current analysis utilises the provision and individual workers files of the National Minimum Data Set for Social Care (NMDS-SC), June 2011. The NMDS-SC collects both aggregate and detailed information on the social care workforce from employers. Completion of the NDMS-SC by providers is not compulsory but there are some financial and training incentives. Skills for Care (SfC) estimates that currently NMDS-SC covers over 50 per cent of social care providers in England[2].

To investigate the possible association between the geographical characteristics of an area and the prevalence of British BME workers, we used rural-urban classifications down to Council with Social Services Responsibility (CSSR) level[3]: three-way classifications of 'Predominantly Rural' (R50 and R80), 'Significant Rural' (SR) or 'Predominantly Urban' (OU, MU and LU) are obtained for each CSSR. The Rural/Urban definition, an official National Statistic introduced in 2004, defines the rurality of very small census-based geographies. 'Predominantly Rural' areas have from 50 to 80 per cent of their population living in rural settlements or large market towns. 'Significant Rural', indicates that a district has between 26 and 50 per cent of its population living in rural settlements and large market towns. 'Predominantly Urban' areas are those with at least 50 per cent of the population living in urban centres. These data were linked to the NMDS-SC provision dataset and analysed to explore possible associations between whether an area is rural or urban and the level of contribution of British BME workers to the sector care sector.

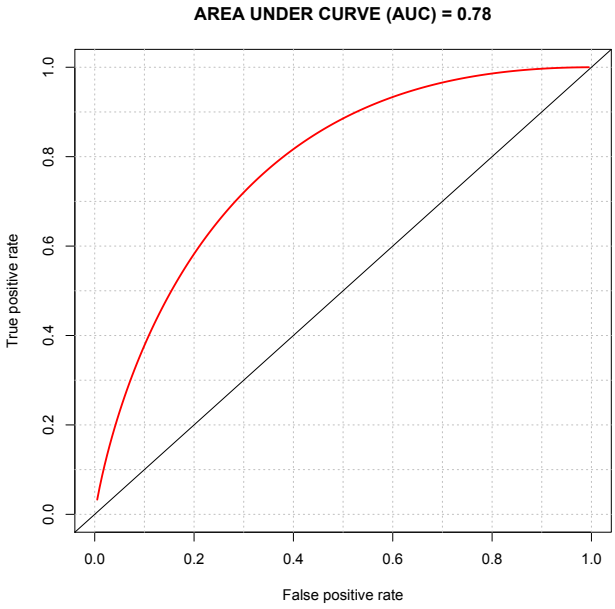
NMDS-SC, June 2011, provides information on a total 646,926 workers; 357,869 of these workers' records have valid information on both ethnicity and nationality. The focus of the analysis in this report is on the group of workers identified as 'British workers'. Among these it is possible to examine the effect of ethnicity, by comparing the group classified by employers as White British with those who are identified as BME British (incorporating a range of Census classifications). The analysis allows us to understand the variability of British BME contribution to the care sector according to different local and organisational characteristics. We also investigate variations in the source of recruitment of White British and BME workers.

We explored the profile of British BME workers using a number of statistical techniques. We then modelled the profile of British BME workers relative to their White counterparts using a logistic regression model. The purpose of this model is to examine whether British BME workers have a distinctive personal and work

[2] Information circulated to the NMDS-SC Data User Group of which the author is a member
[3] Downloaded from the Office for National Statistics (ONS) website, www.ons.gov.uk)

profile that is different from their White British counterparts. The model identifies which types of jobs British BME workers are more likely to perform, which organisations are more successful in attracting them and whether their employment status and working patterns are different from similar groups of White British workers.

Figure 1 Area under curve for the logistic regression model



For the logistic regression model, the outcome variable is whether a worker is identified by employer to be British BME or not. The following variables were included in the initial regression model (the final model only presents those found to have significant association with migration): region, age, gender, any disability, induction status, sector (public, private, voluntary etc.), organisation size, turnover rate within organisation (low, medium, high), vacancy rate within organisation (low, high), main job role group[4], employment status of worker (permanent, temporary, agency or other[5]), work patterns (full time, part time or flexible), type of settings (residential, domiciliary, etc.), and working within organisations providing services to different service user groups. A total of 279,415 workers' records are included in the model, the final model had an Area Under Curve (AUC) measure of 0.78 (see Figure 1) indicating the very good discriminatory power of the model.

[4] Grouped as: 1. 'Managers/supervisors': senior management, middle management, first line manager, registered manager, supervisor, managers and staff in care-related jobs; 2. 'Direct care': senior care worker, care worker, community support, employment support, advice and advocacy, educational support, technician, other jobs directly involving care; 3. 'Professional': social workers, occupational therapists, registered nurse, allied health professional, qualified teacher; 4. 'Other': administrative staff, ancillary staff, and other job roles not directly involving care.

[5] Other includes bank or pool staff, students on placements and volunteers.

Workforce Ethnic Diversity

Social care is an employment sector in which some ethnic groups appear to be over-represented while others are under-represented compared to the overall population. Available data, mainly from the NMDS-SC, indicate that overall between 80 per cent and 85 per cent of the workforce is White, although this proportion varies within different settings; for example, it is higher in domiciliary (home care) than in residential care. The proportion of BME staff further varies in different settings and sectors, ranging from an estimated 25 per cent in independent (private and voluntary sector) sector care homes with nursing, 15 per cent in domiciliary care and nine per cent in day care services. In 2009 around 85 per cent of all adult social care jobs were held by White and 15 per cent by BME staff. In local authorities and the NHS, around 80 per cent of social workers and 90 per cent of occupational therapists are White (Skills for Care 2010). However, these figures do not separate between migrants and British BME workers and consequently over estimate the contribution of 'British' BME workers.

Analysis of the NMDS-SC, June 2011, focusing on workers about whom there is valid information on both ethnicity and nationality, shows that 7.5 per cent (n=26,789) of workers were identified by their employers as British BME workers (Table 1). This percentage is much lower than the 19 per cent identified as belonging to BME groups without accounting for nationality. A total of 14 per cent were identified as migrants, with 3 per cent being White migrants (e.g. from Australia or EU countries).

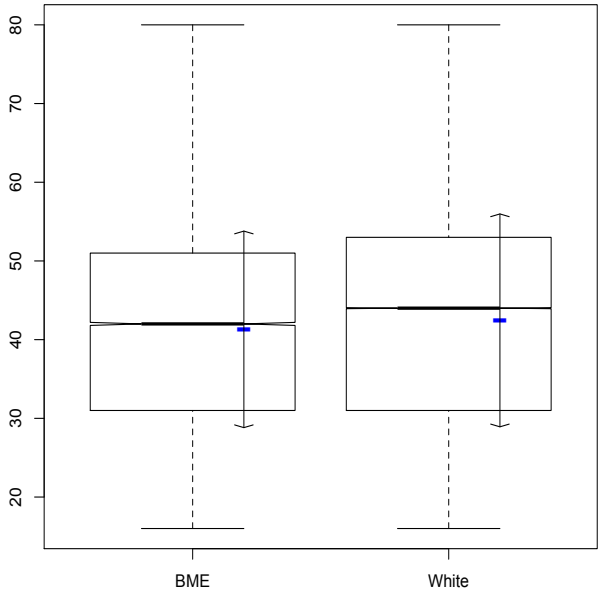
Table 1 Distribution of workers by ethnicity and nationality, NMDS-SC June 2011

Ethnicity and nationality	Number of workers	Per cent
White British	280,786	78.5%
BME British	26,789	7.5%
White migrants	10,780	3.0%
BME migrants	39,514	11.0%
Total	357,869	100.0%

Focusing on those identified as British (n=307,575), 91.3 per cent belong to 'white' ethnicity and 8.7 per cent (n=26,789) belong to BME groups. Among BME workers, 38 per cent were identified as Black or Black British, 30 per cent as 'Other' ethnicities, 22 per cent as Asian or Asian British and 10 per cent as mixed.

Personal characteristics

Figure 2 Box plots of age distribution of British BME and white workers, NMDS-SC June 2011



The average age of both BME and white British workers is in the early 40s, albeit a slight younger age among British BME workers ($\bar{X}$= 41.3 vs. 42.5 years; σ=12.5 and 13.5; median= 42 vs. 44 years). Figure 2 shows that the median age of British BME workers is significantly lower than that of White workers (using Tucky's visualisation notches); also that the distribution of age is narrower for British BME workers. However, previous analysis showed that younger workers (18-25 years) in the care sector are less ethnically diverse than older workers (Hussein and Manthorpe 2010). The fact that, in comparison with other workers, younger workers are less diverse in terms of ethnicity highlights the possibility that young adults from BME groups are not attracted to, or not encouraged by, the care sector. Robinson and colleagues (2006) highlight the low awareness of career opportunities in health and social care among different young BME people. Simultaneously, careers in the care sector may not be seen as attractive by families and peers.

Observed differences in ethnicity by age are likely to be linked to educational attainments among young adults, particularly among females, who constitute the large majority of care workers in England. In the education system, Key Stage 4 results for 16-year-olds are regarded as a significant determinant of their employment prospects (Wilson et al 2005). For example, a recent study shows that after accounting for socio-economic variables, white British pupils from low socio-economic status backgrounds made the least progress over the course of secondary schooling, while Asian pupils, particularly girls, obtained the best results (Strand, 2008). The latter, or their parents, may not be attracted to social care work, given its low status, poor pay and perceived low skill demands.

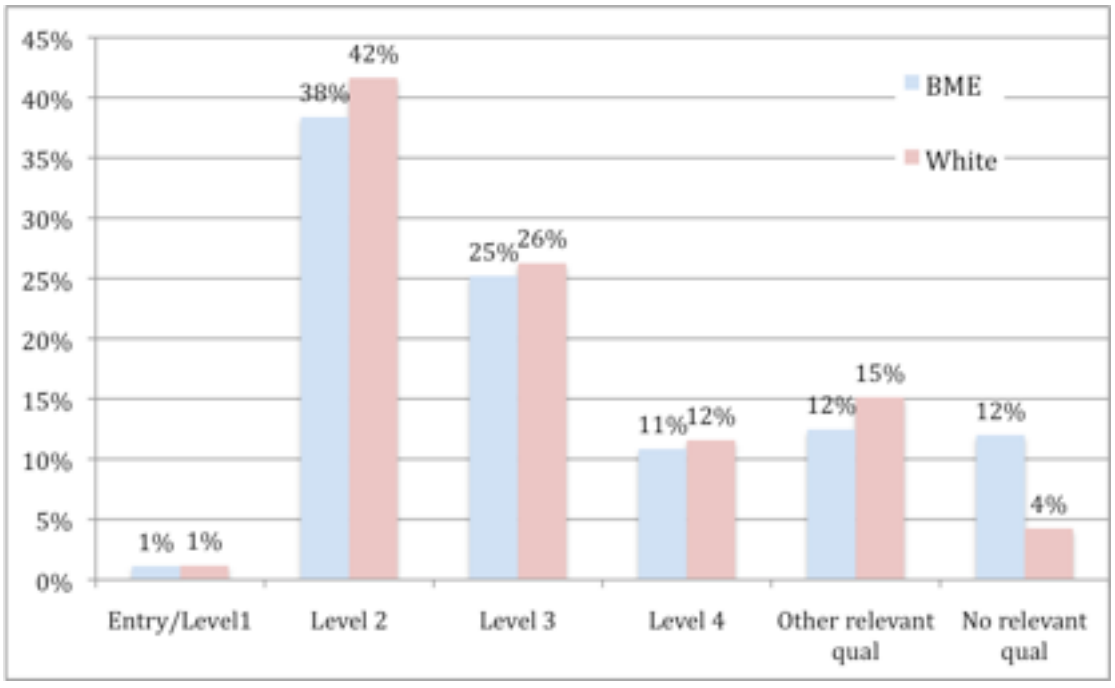
In terms of gender, 11.6 per cent of British BME workers are men, this compares to only 8 per cent among British white workers (χ^2= 591.2, d.f.=1, p<0.001). The higher prevalence of men within the BME worker cohort is likely to be associated with differentials in cultural perceptions of care. These results confirm recent analysis of the characteristics of men in the care sector (Hussein 2011a). Some of these variations may be attributed to economic factors and unemployment rates;

for instance, the care sector is an almost 'recession proof' sector and has the ability to absorb some labour 'spill over' from other sectors.

Significantly more White British workers were identified by their employers as having any form of disability than BME British workers (1.8% vs. 1%; χ^2= 98.2, d.f.=1, p<0.001). These differences may be related to different disclosure patterns by race and may be linked to empowerment and sense of security in the workplace (Ellison et al 2003).

Understanding the interactions between ethnicity, gender and educational attainment in relation to the position of the care sector in the labour market overall is crucial for policy initiatives that are seeking to attract young adults to the sector. Figure 3 indicates some significant differences between the identified highest qualification levels of White and BME British workers (χ^2= 1373.6, d.f.=5, p<0.001). BME British workers tended to have 'no relevant qualifications' more than their White counterparts (12% vs. 4%). Similarly, proportionally more White British workers held NVQ level 2 or equivalent than British BME workers (42% vs. 38%). This may be a reflection of different job role distributions between the two groups, which will be explored further in this report, but may also reflect differences in career choices, employment discussions, or motivations to join the sector.

Figure 3 Distribution of White and BME British workers by highest qualifications level, NMDS-SC June 2011



Ethnicity and Job characteristics

Social care encompasses several occupations including professional staff, such as social workers, care workers, (allied) health profession staff who are employed in social care, managers, administrative staff and ancillary staff not providing care, among others. The current analysis indicates that similar to the overall workforce, the vast majority of BME British workers provide direct care work. However, findings presented in Table 2 show that BME British workers are significantly over represented in professional job roles but less represented in managerial and other job roles (χ^2= 1645.5, d.f.=3, p<0.001).

Table 2 Distribution of British workers by ethnicity and main job role groups, NMDS-SC June 2011

	BME British		White British	
Main job role group	N	%	N	%
Direct Care	21,331	79.6%	201,093	71.6%
Manager/Supervisor	1,895	7.1%	24,945	8.9%
Professional	1,613	6.0%	11,347	4.0%
Other	1,950	7.3%	43,401	15.5%
Total	26,789	100.0%	280,786	100.0%

Examining the interactions between specific job roles, ethnicity and nationality, Table 3 reveals that specific job roles where BME British workers are relatively over-represented are slightly different from those where migrant workers are over-represented. The analysis shows that, while similar to migrant workers, BME British workers are over represented in registered nurse posts, they differ in terms of representation in other jobs. BME British workers are relatively more represented within counsellor and social work jobs, where they form 11 per cent of counsellors[6] (compared to an average of 8.7%). The over representation of British BME workers in professional job roles, especially social work, is consistent with recent changes in the profile of social work students since the change of social work qualifications to degree level in 2003 (Evaluation of the Social Work Degree in England Team 2008). On the other hand, BME British workers are under represented in non-care providing roles including administrative and ancillary jobs, constituting only 4.7 per cent and 3.1 per cent of these jobs respectively. BME British workers are considerably under-represented in first line and middle management jobs (6.4% and 4.6% respectively). These findings are consistent with previous research, which identified some ethnic-differentials in career progression in the health and social care sectors, where staff from BME groups are more likely to have slower career progression and are less represented within managerial roles than White workers (Elliot et al 2002).

[6] Based on a relatively small number of cases (n=56)

Table 3 Prevalence of British BME workers (as a percentage of British workers) compared to prevalence of migrants (as a percentage of all workers) in different job roles

British BME job roles	% of British BME†	% of Migrant workers‡	Migrant job roles
Registered Nurse	15.4	39.8	Registered Nurse
Counsellor	10.7	16.8	Senior Care Worker
Social Worker	10.7	15.3	Care Worker
Care Worker	10.1	11.4	Other non-care-providing roles
Registered Manager	9.2	11.1	Ancillary staff
Senior Care Worker	8.9	10.0	Nursery Nurse
Supervisor	8.4	9.3	Other care-providing role
Senior Management	8.4	8.7	Community Support
Other non-care-providing roles	7.1	8.1	Social Worker
Advice Guidance and Advocacy	7.0	7.1	Childcare Worker
Middle Management	6.4	7.1	Supervisor
Community Support	6.3	6.0	First Line Manager
Managers/staff not care	4.9	5.7	Registered Manager
Childcare Worker	4.8	5.6	Senior Management
Other care-providing role	4.8	5.3	Middle Management
Administrative	4.7	4.7	Educational Support
Employment Support	4.6	4.1	Educational Assistant
First Line Manager	4.6	4.1	Administrative
Occupational Therapist	3.5	4.0	Counsellor
Ancillary staff	3.1	3.9	Teacher
Nursery Nurse	2.9	3.6	Allied Health Professional
Educational Support	2.5	2.8	Occupational Therapist
Technician	2.2	2.8	Employment Support
Teacher	2.0	2.3	Managers/staff not care
Youth Offending Support	1.0	1.9	Technician
Allied Health Professional	1.0	1.7	Advice Guidance and Advocacy
Educational Assistant	1.0	0.0	Youth Offending Support

† based on British workers only; ‡ based on all workers (extracts from Hussein 2011b)

Previous research showed the importance of having a 'profession', and autonomy and opportunity to make decisions in BME people's choice of careers (Greenwood et al 2006). At the same time, Robinson and colleagues (2006) found that some young BME people regard some care jobs as 'dirty' and 'intimate', which may pose difficulties for both BME men and women. Such perceptions and attitudes, while they may not be generalised, may partly explain the over representation of BME staff in 'professional' jobs such as nursing and social work, however, the data show that they are not under-represented in 'hands on' care jobs.

In terms of working patterns, the current analysis indicates that significantly more BME British workers are employed on flexible arrangements when compared to White British workers (15.6% vs. 8.8%), while fewer are employed part-time (35.2% vs. 42.3) and similar proportions are working on a full time basis (49.2% vs. 48.9%). Figure 4 shows that these patterns of work do not dramatically change within different groups of job roles, except within

managerial roles where almost all BME British workers are employed on full time basis.

The analysis reveals some significant findings relating to ethnicity and type of employment. Table 4 indicates that significantly more white British workers are employed on a permanent basis, while BME British workers are over-represented as temporary and agency workers (χ^2= 2741, d.f.=6, p<0.001). Evidence from research suggests that agency workers are often brought in to 'tackle' certain problems and not only to fill vacancies (Cornes et al 2010), thus agency staff may feel under more work pressure than others. Variations in employment status may be indicative of wider and more important ethnic-gaps in relation to job security and career progression opportunities.

Figure 4 Distribution of British workers by ethnicity, main job role group and pattern of work, NMDS-SC June 2011

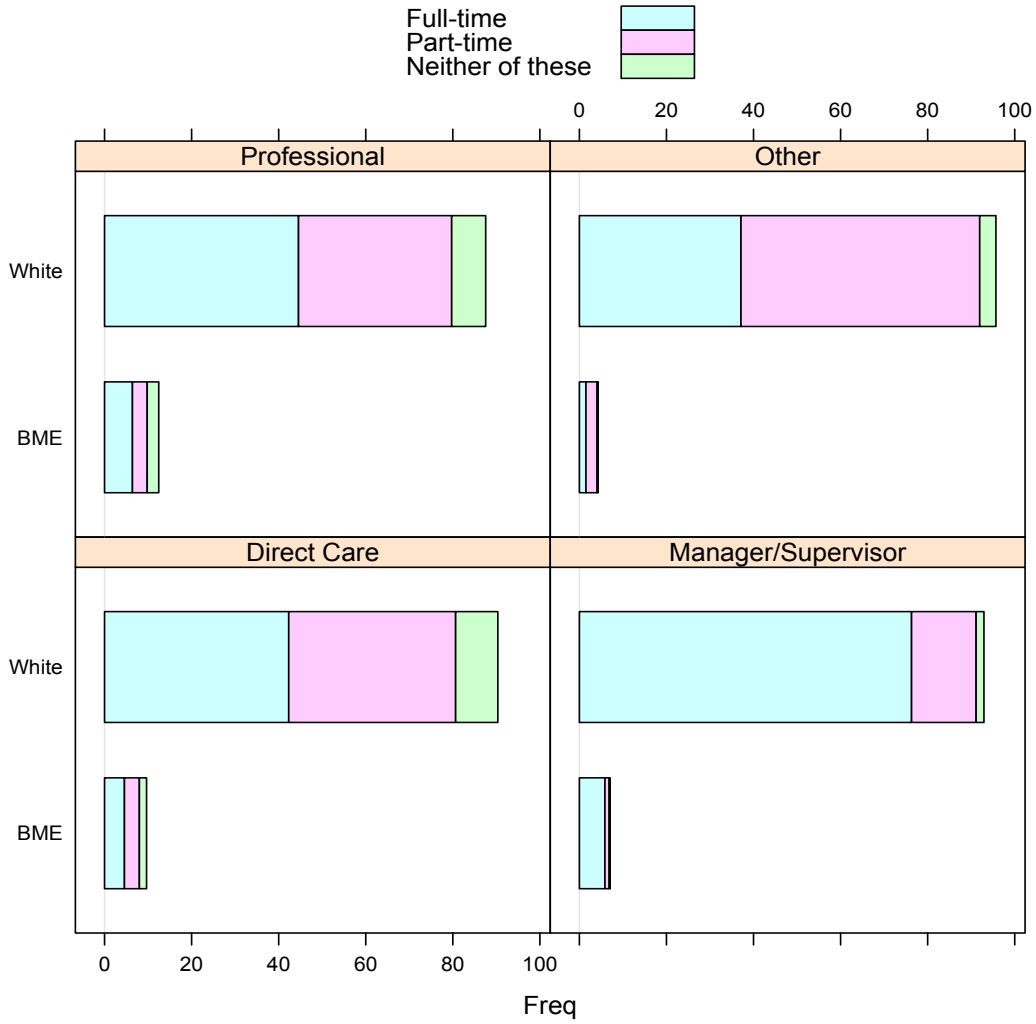


Table 4 Distribution of BME and white British workers by type of employment, NMDS-SC June 2011

	BME British		White British	
Type of employment	N	%	N	%
Permanent	21,268	80.2%	244,936	88.3%
Temporary	2,341	8.8%	9,226	3.3%
Bank or pool	1,739	6.6%	16,045	5.8%
Agency	920	3.5%	4,025	1.5%
Student	12	0.0%	173	0.1%
Volunteer	32	0.1%	340	0.1%
Other	207	0.8%	2,506	0.9%
Total	26,519	100.0%	277,251	100.0%

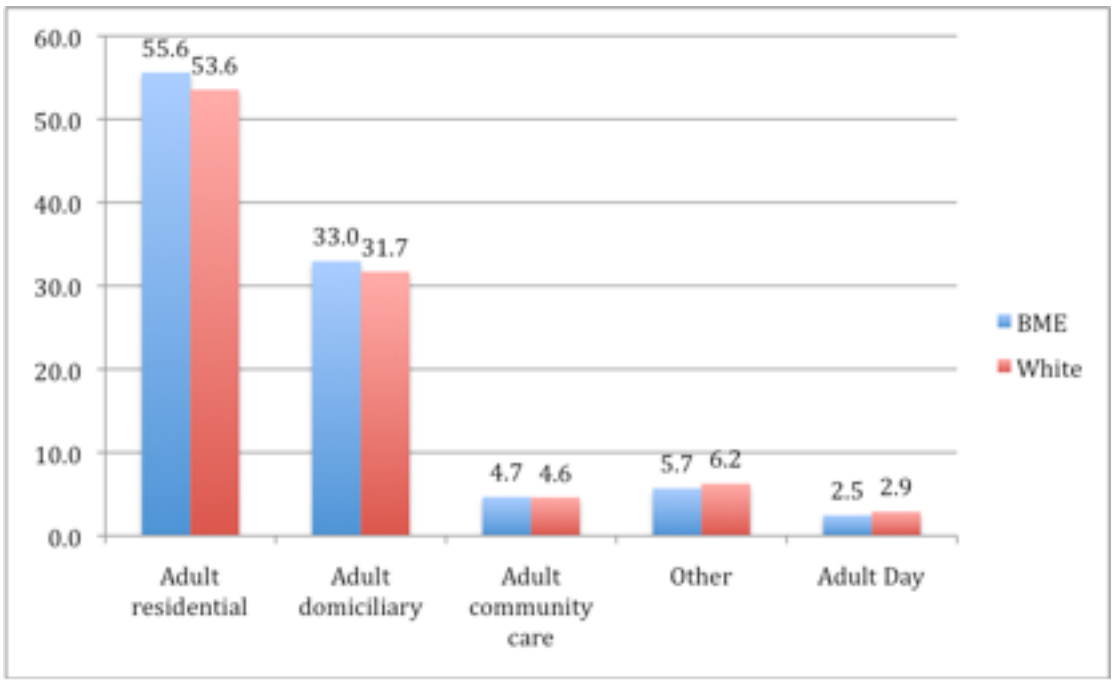
Ethnicity and Organisational characteristics

It is estimated that the independent sector (private and voluntary) employs around 70 per cent of the workforce, with Councils (local authorities) employing 16 per cent, NHS around four per cent and recipients of Direct Payments employ eight per cent of the total social care workforce (Skills for Care 2010). The current analysis confirms the concentration of all British workers within the private sector, however, relatively more BME than White British workers are employed in the private sector (66% vs. 61%), while more white than BME British workers are employed in local authorities (11% vs. 7%). Previous studies have examined differences in working conditions and pay levels in the private and public sectors; with evidence of lower pay and more difficult working conditions in the private sector (Hussein 2010, Rubery et al 2011). The over representation of BME British workers in the private sector, combined with higher chances of temporary employment status, may raise questions about the overall job security of this group relative to other workers.

Figure 5 shows that similar proportions of British BME and White workers work in different settings, with the majority working in adult residential settings. The pattern of distribution is very similar to that of the whole workforce, with the exception that British BME workers are slightly over represented in residential and other[7] settings.

[7] Other settings include children, health care and other settings

Figure 5 Distribution of British BME and white workers by type of setting, NMDS-SC June 2011



Service user groups

The analysis shows that BME British workers are over represented within organisations providing services to certain groups of users. The largest concentration of BME British workers is found in organizations providing services to users who are detained under the Mental Health Act (MHA); whether older people, adults or young people. This is similar to findings related to that of migrant workers (Hussein 2011b). However, there are a number of differences between British BME and migrant workers' contribution in relation to service user groups.

Table 5 Percentage of British BME workers (out of all British workers) in organizations providing services to different user groups, NMDS-SC June 2011

Service user group	% British BME	Total number of British workers
Older people		
With dementia	8.4%	152,203
With learning disabilities	11.3%	142,165
With mental disorders or infirmities	9.7%	101,169
With sensory impairment(s)	8.8%	108,271
Who misuse alcohol/drugs	9.3%	46,673
Detained under the Mental Health Act	11.5%	1,603
With autistic spectrum disorder	12.2%	3,440
With physical disabilities	10.0%	18,975
Others not in above categories	7.2%	140,974

Service user group	% British BME	Total number of British workers
Adults		
With dementia	11.5%	13,042
With learning disabilities	11.3%	142,165
With mental disorders or infirmities	9.7%	101,169
With sensory impairments	8.8%	108,271
Who misuse alcohol or drugs	9.3%	46,673
Detained under the Mental Health Act	17.4%	1,315
With autistic spectrum disorder	7.8%	7,138
With physical disabilities	9.0%	136,742
With an eating disorder	9.8%	2,011
Others not in above categories	8.0%	26,034
Children and young people		
With emotional or behavioural difficulties	11.4%	13,391
With physical disabilities	11.0%	19,608
With learning disabilities	11.1%	21,584
With mental disorders or infirmities	12.8%	10,191
With sensory impairments	10.9%	13,996
Who misuse alcohol or drugs	9.2%	4,068
Detained under the Mental Health Act	19.2%	52
With autistic spectrum disorder	9.4%	2,078
With an eating disorder	8.9%	304
Others not in above categories	11.5%	4,476
Carers		
Of older people	9.9%	29,543
Of adults	13.3%	27,567
Of children and young people	12.2%	10,721
Families	12.5%	12,687
Other not in above categories	8.7%	8,199

Migrant workers are concentrated in organizations providing services to older people with dementia or learning disabilities and adults with physical disabilities or mental health problems. On the other hand, British BME workers appear to be more often working within organisations offering services to carers of adults and children or young people (13% and 12% compared to an average of 8.7%). These variations are associated with specific job roles, with BME British workers over-represented among social workers and nurses (working in social care).

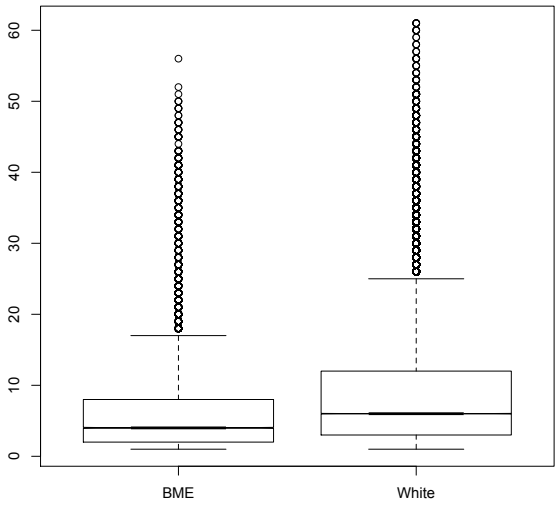
Workforce Stability

Sector is one of the most important characteristics associated with different measures of workforce stability in social care and it appears to reflect the profit or non-profit status of providers. Previous analysis has indicated that employers in the private sector report the largest 'losses' of staff. In 2009, many employers reported positive net-flow rates among both managers/supervisors and professional staff groups; this may relate to employing new staff, or the possibility that employees have gained promotion or further qualifications (Hussein 2009). More recent analysis of longitudinal changes in care workforce

stability indicates that turnover rates have remained chronically high over the period from 2008 to 2010, while the same period saw some reduction in care workers' vacancy rates (Hussein and Manthorpe 2011). The current analysis indicates that BME British workers are employed in organisations with slightly lower turnover rates than those where White British workers are employed ($\bar{X}$=22.5, σ=80 vs. $\bar{X}$=24, σ=79.6). In terms of vacancy rates both White and BME British workers are employed within organisations with similar mean (average) vacancy rates of 2.2 per cent (σ=7 and 6.1 respectively).

Until recently the NMDS-SC collected information on the number of years a worker had spent in the care sector and measures of continuity of work. Collecting information on continuity of work in the care sector was removed by Skills for Care from the dataset in May 2011 due to the low response rate[8] associated with these items. However, information on number of years of experience in the care sector is still collected and included in the analysis. Figure 6 indicates that for White British workers the mean number of years in the sector is 8.7 years compared to 6.3 years among BME British workers. Moreover, Figure 6 also shows that the distribution of number of years in the sector is wider among White British workers than BME British workers, indicating longer work experience in the care sector among White British workers more generally. Such findings, combined with the higher prevalence of 'non-relevant' qualifications among BME British workers, point to a greater likelihood of BME workers having different work histories from those of White British workers in the care sector. These ideas will be explored further through examining differentials in source of recruitment of White British and BME workers.

Figure 6 Distribution of number of years working in the care sector among British workers by ethnicity, NMDS-SC June 2011



Ethnicity and recruitment to the care sector

Providers completing NMDS-SC, June 2011, indicated that significantly higher proportion of White British workers had been recruited from retail and other sectors than BME British workers. For example, Table 6 shows that 5 per cent of White British workers were recruited from the retail sector for their current jobs in social care compared to only 2 per cent of their BME counterparts. Similarly

[8] For details of changes in the NMDS-SC data items see http://www.nmds-sc-online.org.uk/content/view.aspx?id=Confirmed%20changes

11 per cent of the former group were recruited from other sectors compared to only 7 per cent among the latter group; these differences are statistically significant (χ^2= 15780.5, d.f.=14, p<0.001). This may indicate that the care sector is attracting some White British workers from outside care occupations more than it does in relation to BME British workers. These findings may highlight a need for recruitment campaigns to attract new recruits from diverse backgrounds thus expanding pools of recruitment. Interim findings from the Longitudinal Care Study (LoCS) indicate that over 50 per cent of workers in the care sector who responded to a large survey (n=1,025) have family or friends also working in social care (Hussein et al 2010b). This supports anecdotal evidence from within the sector that people are more likely to be attracted to social care through personal contacts than from advertising or advice from careers' services or job advisors. The differences exposed here in relation to source of recruitment indicate a need for greater attention in devising recruitment campaigns that appeal to diverse communities. These findings are consistent with previous research that highlights considerable knowledge gaps about careers in the health and social care sectors among different groups of BME communities in the UK (Helm et al 2001, Greenwood et al 2006; Robinson et al 2006).

Table 6 Distribution of British BME and White workers by source of recruitment to current job in social care

Source of recruitment to current job	British BME	British White
Social care sector	46.1%	51.3%
Health sector	7.9%	5.3%
Retail sector	2.2%	4.5%
Other sectors	6.6%	10.5%
Not previously employed	3.0%	3.9%
From abroad	1.1%	0.1%
Agency	8.8%	2.4%
Other sources	24.3%	22.1%
Number of workers[9]	11,970	170,989

On the other hand, relatively more BME British workers were recruited through agencies or from the health sector. Significantly more British BME workers had been recruited through agencies than White British workers (9% vs. 2%). In social care, the agency workforce is very diverse, ranging from experienced professionals providing managerial expertise or consultancy at senior levels to part time or one off workers in care homes or domiciliary settings. Hoque and Kirkpatrick (2008) estimated that approximately half of all agency/temporary workers in English social services were professionally qualified social workers, the majority being employed in higher risk services for children and families with the vast majority based in London. Cornes and colleagues' (2010) recent survey of social services directors found that the majority saw agency workers as playing an important role in 'keeping the show on the road'. The same research also showed that many agency workers saw this type of working as

[9] With available information on source of recruitment

advantageous, not only in terms of flexibility but also the opportunities for broadening their practice experiences.

Ethnicity and local area characteristics

It is likely that the recruitment of people from diverse backgrounds will be associated with levels of overall diversity among the local population, with different regions and areas in England offering a potentially more or less diverse pool of workers. Local population diversity is also associated with the diversity of user groups and potential 'demand' for certain groups of workers. Table 7 confirms such a view, with BME British workers constituting 41 per cent of all British workers in London. The same region also has the highest contribution of migrants (Skills for Care 2011, Hussein 2011b). On the other hand, the prevalence of BME British workers is lowest, at only 3 per cent, in the North East region of England. The North East region is the smallest region in England with particularly lower proportions of BME people in the local population than the overall average in England (2.4% compared to 8.7%). A study on equality and diversity within this region found that both health and income inequalities were evident, with some people from minority groups expressing high levels of isolation and rejection (Penn and Shewell 2005).

Table 7 Distribution of workers by ethnicity and region, NMDS-SC June 2011

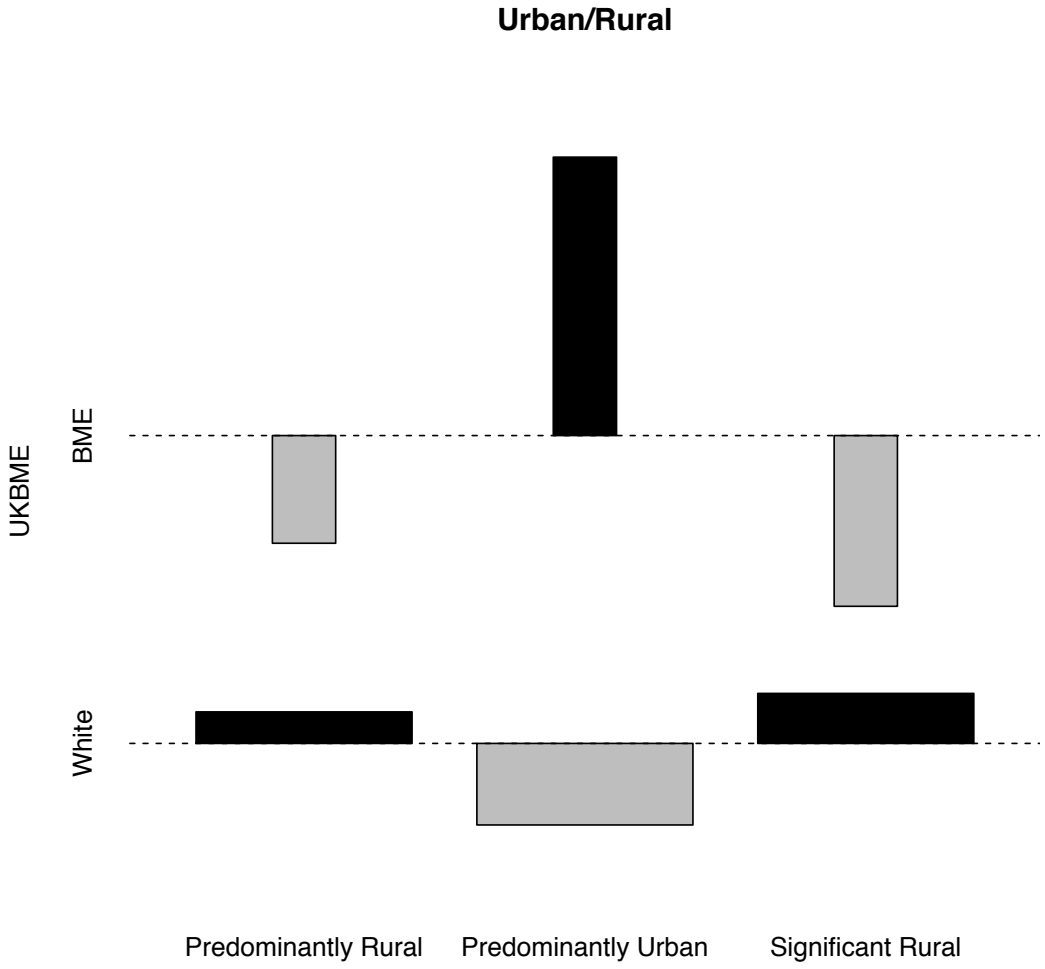
	BME British		White British	
Region	N	%	N	%
London	7,488	41.3	10,647	58.7
West Midlands	3,715	9.2	36,604	90.8
South West	3,210	8.0	36,827	92.0
Eastern	2,424	7.8	28,732	92.2
East Midlands	2,221	7.4	27,975	92.6
Yorkshire & Humber	2,211	6.7	30,917	93.3
South East	2,910	6.6	41,213	93.4
North West	1,875	4.0	44,576	96.0
North East	688	2.9	22,935	97.1

The level of rurality of a locality also affects labour engagement by different groups in different sectors. Using information on local area rurality level (as explained in the Methods section) linked to NMDS-SC data we were able for the first time to investigate the prevalence of BME British workers within predominantly rural, significantly rural and predominantly urban areas. Consistent with findings related to regional differentials, Table 8 indicates that the prevalence of BME British workers is highest within predominantly urban areas (with at least 50 per cent of the population living in urban centres) and lowest within significantly rural areas (areas where 26 and 50 per cent of its population living in rural settlements and large market towns). These differences are statistically significant and are represented in Figure 7.

Table 8 Distribution of British workers by ethnicity and local area level of rurality

	BME British		White British	
Local area level of rurality	N	%	N	%
Predominantly Rural	4,013	6.0	63,194	94.0
Predominantly Urban	17,789	12.9	120,200	87.1
Significant Rural	4,940	4.8	97,032	95.2

Figure 7 Cohen-Friendly association plot of level of rurality and ethnicity of British workers



Differentials between British BME and White workers in the care sector

To understand further which organisational and personal characteristics are more likely to increase the likelihood of British BME participation in the social care workforce, while controlling for other factors, we conducted a logistic regression model with the outcome being whether a worker belongs to a BME group or not. We included several personal and organisational variables as 'independent' factors and the final model with factors associated with the probability of a worker being from a British BME group is presented in Table 9. The analysis indicates significant differences between British BME and White British groups at different levels, including personal, local area, organisational and job characteristics.

On a personal characteristic level, British BME workers are significantly less likely to be women (Odds Ratio (OR)= 0.71; $p<0.001$) and to report any form of disability (OR=0.60; $p<0.001$). Disability disclosure in employment is likely to be associated with levels of work autonomy and empowerment and may indicate a lower confidence among BME workers to disclose their disabilities to their employers for fear of losing their jobs, for example. This may be especially the case given the higher likelihood of British BME workers to be employed on temporary contracts or on a flexible basis. However, there may be other explanations that further research might identify.

In terms of gender, the relative under representation of BME British women within the sector in comparison to White British workers may reflect some of Robinson and colleagues' (2006) findings related to perceptions of the unsuitability of care work for women among some BME communities. British BME workers are significantly more likely to hold entry/level 1 qualifications, other (not directly relevant) qualifications or not hold any qualifications at all than NVQ level 2 when compared to British White workers (OR=1.75, $p<0.001$; OR=3.08, $p<0.001$; OR=1.73, $p<0.001$ respectively). Such a strong finding, combined with findings related to source of recruitment of British BME workers being more likely to be from within the care sector, may be indicative of the unattractiveness of the care sector as a career 'choice' for some British BME people. The findings indicate that the sector may attract BME people with relatively low levels of qualifications who may not be able to find jobs in other sectors. The sector also appears to attract some people who did not make a career 'choice' to join the care sector and who have gained 'other non-relevant' qualifications but end up working in the sector for different reasons. Such observations are important in setting recruitment campaigns that are attractive to different groups who may not necessarily actively seek information related to the care sector.

Local population density and level of rurality of an area are significantly associated with the level of participation of BME British groups in the care sector. The findings indicate that participation levels are highest in London

(OR=6.33, $p<0.001$) where the local population is the most diverse in the whole UK (according to the 2001 census, BME groups constituted one-third of the population in London. It is likely that their percentage has increased since then). Similarly, British BME workers are significantly more likely to be working in predominantly urban than rural areas (OR=1.82, $p<0.001$), where previous studies indicate the concentration of BME groups in deprived urban areas (Parliament Office of Science and Technology 2007).

Table 9 Results of the final logistic regression model (AUC= 0.78)

Significant variables in final logistic regression model	Odds Ratio	Confidence Interval Lower bound	Confidence Interval Upper bound	Std. Error	z value	*p*-value
PERSONAL CHARACTERISTICS						
Women vs. men	0.71	0.68	0.74	0.02	-18.4	<0.001§
Any disability vs. none	0.60	0.52	0.68	0.07	-7.3	<0.001§
Highest qual level (ref: Lev 2)						
Not recorded	0.78	0.73	0.82	0.03	-8.5	<0.001§
Entry/Level1	1.75	1.42	2.15	0.11	5.3	<0.001§
Level 3	0.91	0.86	0.96	0.03	-3.3	0.001‡
Level 4	0.99	0.91	1.07	0.04	-0.3	0.768
Other relevant qual.	0.95	0.89	1.02	0.04	-1.3	0.193
Any other qual.	3.08	2.85	3.33	0.04	28.1	<0.001§
No qual. held	1.73	1.67	1.81	0.02	26.6	<0.001§
LOCAL CHARACTERISTICS						
Region (ref: Eastern)						
East Midlands	1.23	1.15	1.32	0.04	5.8	<0.001§
London	6.33	5.95	6.74	0.03	58.4	<0.001§
North East	0.32	0.29	0.35	0.05	-24.1	<0.001§
North West	0.40	0.38	0.43	0.04	-25.5	<0.001§
South East	0.97	0.91	1.04	0.03	-0.9	0.379
South West	1.06	1.00	1.13	0.03	2.0	0.041†
West Midlands	1.22	1.15	1.30	0.03	6.6	<0.001§
Yorkshire & Humber	0.66	0.62	0.70	0.03	-12.4	<0.001§
Rurality (ref: Predominantly rural)						
Predominantly Urban	1.82	1.74	1.90	0.02	26.1	<0.001§
Significant Rural	0.71	0.68	0.75	0.03	-12.7	<0.001§
ORGANISATIONAL CHARACTERISTICS						
Sector (ref: Local authority)						
Private	1.34	1.25	1.43	0.03	8.6	<0.001§
Voluntary	0.80	0.74	0.85	0.04	-6.5	<0.001§
Other	0.83	0.75	0.92	0.05	-3.6	<0.001§
Turnover rate (ref: low)						
Medium	1.07	1.04	1.11	0.02	3.9	<0.001§
High	0.90	0.87	0.93	0.02	-5.6	<0.001§
Vacancy rate high vs. low	0.72	0.69	0.75	0.02	-16.5	<0.001§

Significant variables in final logistic regression model	Odds Ratio	Confidence Interval Lower bound	Confidence Interval Upper bound	Std. Error	z value	*p*-value
Type of setting (ref: residential)						
Adult Day	0.62	0.56	0.68	0.05	-9.7	<0.001§
Adult domiciliary	0.47	0.46	0.49	0.02	-40.0	<0.001§
Adult community care	0.71	0.66	0.76	0.04	-8.8	<0.001§
Children's services	0.72	0.62	0.83	0.07	-4.5	<0.001§
Healthcare	3.91	0.91	15.41	0.70	1.9	0.053
Other	0.51	0.46	0.55	0.04	-15.3	<0.001§
JOB CHARACTERISTICS						
Main job role (ref: direct care)						
Manager/Supervisor	0.80	0.75	0.85	0.03	-7.2	<0.001§
Professional	2.26	2.11	2.42	0.03	23.3	<0.001§
Other	0.48	0.46	0.51	0.03	-25.6	<0.001§
Employment status (ref: permanent)						
Other	0.73	0.68	0.78	0.04	-8.9	<0.001§
Temporary	2.11	1.98	2.25	0.03	23.3	<0.001§
Agency	1.47	1.33	1.62	0.05	7.8	<0.001§
Work pattern (ref: full time)						
Part-time	0.96	0.93	0.99	0.02	-2.6	0.011†
Neither of these	1.38	1.30	1.46	0.03	10.6	<0.001§
Induction (ref: completed)						
Induction in Progress	0.97	0.92	1.02	0.02	-1.2	0.217
Not applicable	0.69	0.66	0.73	0.02	-15.9	<0.001§
Service users						
Adults with LD	1.90	1.84	1.96	0.02	38.6	<0.001§
CYP with mental disorders	1.41	1.31	1.51	0.04	9.2	<0.001§
Older people with LD	1.37	1.27	1.49	0.04	7.6	<0.001§
Older people with ASD	0.46	0.39	0.53	0.08	-10.3	<0.001§

† Significant with p-value<0.05; ‡ significant with p-value<0.005; § significant with p-value<0.001, LD= learning disability; CYP= children and young people; ASD=Autism Spectrum Disorder

The logistic regression model results highlight several organisational characteristics that are significantly associated with the likelihood of BME British workers' presence in the workforce. British BME workers are significantly more likely to work in the private sector than local authorities when compared to their White British counterparts (OR=1.34, p<0.001) and in organisations offering residential care after controlling for other factors. While British BME workers are more often employed in organisations with medium than low turnover rates than White British workers, the magnitude of difference is not particularly large (OR=1.07, p<0.001) and they are significantly less represented in organisations with high turnover rates (OR=0.9, p<0.001). On the other hand, the former group is more likely to be working in organisations with lower vacancy rates, which may relate to the purpose of their recruitment in the first place (i.e. to fill vacancies or to meet specific demand). Findings related to turnover and vacancy

rates may paint a picture of higher employment attachment among British BME than white workers, thus a higher prevalence of British BME workers may contribute to keeping both turnover and vacancy rates lower than average.

In terms of job characteristics, the model shows that BME British workers are significantly more likely to perform professional and direct care jobs (reference category) than managerial or supervisory roles when compared to white British workers (OR=2.26, 0.80; $p<0.001$ respectively). Specific job role patterns may reflect both the attitude of BME groups to different jobs as well as the skills capital of different groups of BME workers. Some BME British workers hold specialised qualifications, especially social work and nursing, which allow them to perform professional jobs. At the same time there is another group of workers who do not hold any relevant qualifications who are likely to perform basic care jobs, after completing their induction (given the significantly higher likelihood of BME workers to complete their induction). However, the latter group may not have enough skills capital or relevant work experience to progress into managerial or supervisory roles, or they encounter other structural and institutional barriers.

BME British workers are also significantly more likely to hold temporary contracts or to work through agencies than holding permanent positions relative to their white British counterparts, highlighting possible greater job insecurity among BME workers. These findings are mirrored by findings related to working patterns, where BME British workers are significantly more likely to work on a flexible basis (OR=1.35, $p<0.001$). In relation to service user groups, BME British workers are significantly more likely to be working with older people and adults with learning disabilities and with children or young people with mental health problems (OR-1.37, 1.90 and 1.41, $p<0.001$ respectively).

Discussion

The National Minimum Data Set for Social Care (NMDS-SC) now collects information on both ethnicity and nationality of the social care workforce, providing a unique opportunity to enhance the understanding of the contribution of British BME workers and not to confuse this group with recent migrants working in the sector. The current analysis, which uses NMDS-SC June 2011, highlights several distinct characteristics of British BME workers within the care sector in comparison to their White British counterparts. The overall contribution of British BME workers is considerably lower than that estimated previously, simply because this analysis has separated British BME workers from BME workers from other nationalities who are likely to be recent migrants. British BME workers constitute 7.5 per cent of all workers reported in the NMDS-SC, June 2011, and 8.7 per cent of all British workers identified by the same dataset. Nearly 40 per cent of British BME workers are identified by employers to be of Black or Black British ethnicity and 22 per cent as being Asian or Asian British, with a considerable proportion of 30 per cent being identified as belonging to 'other' ethnic groups. Such distribution does not reflect the overall ethnic distribution of England and Wales where the largest ethnic group is Asian or Asian British at 5.9 per cent of the population followed by 6.2 per cent of 'other' ethnicities (including Chinese) then Black or Black British at 2.8 per cent and mixed ethnicities at 1.8 per cent (ONS 2011; www.ons.gov.uk). The high prevalence of workers from Black and Black British ethnicities is not just confined to direct care workers but is consistent with an increase in social work students from this group since the introduction of the new social work degree in 2003 (Evaluation of the Social Work Degree in England Team 2008). The relative under-representation of workers from Asian ethnicity may be related to perceptions of care work status and suitability among Asian communities in the UK, particularly young women (Robinson et al 2006).

British BME workers are slightly younger than White British workers; however, the two groups share a relatively high median age. Moreover, younger workers (18-25) in the sector are less ethnically diverse from their older counterparts (Hussein and Manthorpe 2010) raising questions about how careers in social care are perceived and portrayed to young adults from different communities. Observed differences in ethnicity by age are also likely to be linked to educational attainment among young adults, particularly among females, who constitute the large majority of care workers in England. These are again linked to recruitment to the sector. While making information available about different career options in the sector to young adults at secondary school level options may be useful, it will not on its own address the ambitions of young people and their parents to step away from low paid work. The analysis also highlights the interesting over-representation of men among British BME workers and the under-representation of workers with disabilities. The former may point to gender-differentials of cultural acceptance or rejection of certain jobs and whether some of care jobs are regarded as too intimate or not suitable for

women, especially if the service user is male, or jobs that require and reward physical strength and assertiveness. The low level of disclosed disabilities among British BME workers might be related to feelings of autonomy and fear of losing a job if a disability is disclosed.

Several important findings related to the recruitment of British BME workers to the care sector are highlighted by the analysis. Significantly smaller proportions of British BME workers are recruited to their current jobs from outside the care sector and large proportions are working through agencies. On average, British BME workers have fewer years of experiences than White British workers. Additionally, significantly more British BME workers do not hold relevant qualifications. Other findings suggest that some British BME workers in the sector have worked outside it and may have not made a 'choice' of a career in social care, but may have ended up working in the sector – either as a positive choice or a lack of alternative. At the same time, workforce stability measures suggests that British BME workers are more concentrated in organisations with low vacancy and turnover rates, suggesting a higher degree of job attachment among this group.

British BME workers are significantly more likely to have either professional jobs, especially nursing and social work, or direct care jobs and less likely to be employed in managerial or supervisory roles. Such findings, combined with different qualification patterns, may suggest that the care sector attract two British BME groups, the first group with a higher skills capital (or potential) that chooses or is able to specialise in certain 'professions' and a second with lower skills but capable of performing care jobs but not equipped or able to move on to managerial or supervisory roles. The latter group may have overall limited career progression opportunities either due to their low educational attainment or because of organisational and structural factors that may hinder their career progression potential as suggested in the literature (e.g. Elliot et al 2002).

Another important finding highlighted from this analysis are the apparent differentials in relation to job security between British BME and White British workers in the care sector. British BME workers are significantly more likely to face job and employment insecurities because of differentials in employment status and working patterns. Significantly more BME British workers are employed on temporary or flexible basis and are recruited through agencies reflecting less favourite work conditions that are usually attached to these types of contracts, despite better legal safeguards introduced in 2011. British BME workers are also significantly more likely to be employed in the private sector than White British workers, which is characterised by harder working conditions and less favourable pay levels (Hussein 2010a, Rubery et al 2011).

From a policy perspective, the current analysis highlights a need to actively promote social care careers among British BME groups, especially at a time where immigration policies may be restricting the recruitment of non-EEA nationals. Efforts need to be made to positively improve the image of non-professional social care jobs among different communities. Career progression is an important factor in attracting workers to any sector; within the care sector

efforts should be focused on tackling any possible ethnic discrimination and ensuring all workers have equal opportunities to gain promotion. Opportunities for workers with unrelated qualifications and experiences to join this workforce should be promoted and made visible during recruitment processes, especially when approaching BME communities. At a time of redundancies this may be particularly relevant and new skills may improve productivity.

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